The Government's response to the Health and Social Care Committee's Expert Panel Evaluation

The Government's progress against its policy commitments in the area of maternity services in England

September 2021

CP 514

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Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

September 2021

CP 514

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1. Introduction

1. This is the Government's formal response to the Health and Social Care Committee's Expert Panel 'Evaluation of the Governments progress against its policy commitments in the area of maternity services in England'[1].
2. The Government welcomes this report. We are considering the Panel's findings carefully as part of on-going policy development.
3. The Expert Panel evaluated the following four Government commitments on maternity services:
   - **Maternity Safety:** By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025.
   - **Continuity of Carer:** The majority of women will benefit from the 'Continuity of Carer' model by 2021, starting with 20% of women by March 2019. By 2024, 75% of women from black, Asian and Minority ethnic communities and a similar percentage of women from the most deprived groups will receive Continuity of Care from their midwife throughout pregnancy, labour and the postnatal period.
   - **Personalised Care:** All women to have a Personalised Care and Support Plan (PCSP) by 2021.
   - **Safe Staffing:** Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.
4. The Expert Panel rated the Government's progress against each of these commitments using a 'Care Quality Commission-style' (CQC) rating. The overall rating across all four commitments was 'requires improvement'.
5. The CQC-style ratings for each of the commitments are summarised below.

[1] https://committees.parliament.uk/publications/6560/documents/71747/default/

Commitment	Commitment Met	Funding/ Resourcing	Impact	Appropriate	Overall
Overall Rating					Requires Improvement
Maternity Safety	Stillbirths – Good Neonatal Deaths – Good Brain Injury – Requires Improvement Maternal Deaths – Inadequate Pre-Term Births – Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement
Continuity of Carer	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement
Personalised Care	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate
Safe Staffing	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Requires Improvement

6. The Panel's report sets out its findings in five chapters; one chapter for each of the commitments it evaluated, and an additional chapter relating to health disparities. The Department's response corresponds to this structure.

The Committee's Inquiry into the Safety of Maternity Services in England

7. The Health and Social Care Committee also began its inquiry into the Safety of Maternity Services in 2020. The Committee published its report on 6 July. [2]

8. The Committee's report made 15 recommendations. The Department has separately responded to the committee's report.

[2] https://committees.parliament.uk/publications/6578/documents/71418/default/

2. Maternity Safety

Commitment - By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025.

9. The panel rated the Departments progress against this commitment as follows:
    a. Overall – Requires Improvement
        i. Commitment Met:
            1. Stillbirths – Good
            2. Neonatal Deaths - Good
            3. Brain Injury – Requires Improvement
            4. Maternal Deaths – Inadequate
            5. Pre-Term Births – Requires Improvement
        ii. Funding – Requires Improvement
        iii. Impact – Requires Improvement
        iv. Appropriate – Good

Summary of Response

10. The Government's original National Maternity Safety Ambition was to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring during or soon after birth by 2030.
11. The ambition was updated in 2017 to bring forward the ambition date to 2025 and to include an additional ambition to reduce the rate of pre-term births from eight percent to six percent.
12. Good progress has been made towards meeting some elements of the ambition. The Office for National Statistics (ONS) reports that since 2010, there has been a 25% reduction in the stillbirth rate, and a 29% reduction in the neonatal mortality rate for babies born over the 24-week gestational age of viability. This means that there are hundreds more mothers and families going home with a live, healthy baby each year.
13. The Government accepts that progress on reducing the maternal mortality rate, the brain injury rate and the pre-term birth rate has been slower.
14. The Government has introduced a number of initiatives to accelerate progress against these elements of the ambition. Through commitments outlined in the NHS Long Term Plan (January 2019)[3] and The NHS Patient Safety Strategy (July 2019)[4], efforts to implement key safety initiatives are being maintained. The Long Term Plan also includes new measures to improve safety, quality and Continuity of Care that will help achieve our ambition to halve stillbirths, maternal and neonatal deaths and serious brain injuries in babies by 2025.

[3] https://www.longtermplan.nhs.uk
[4] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/#patient-safety-strategy

15. It is important to note that implementation of Maternity Safety Strategy initiatives has been staggered over the last three years. Some initiatives aimed at addressing mortality, such as Maternal Medicine Networks, and the Neonatal Critical Care Review recommendations, are only now beginning to be implemented, meaning that the impact of many initiatives is still to be realised.
16. The Government accepts that whilst the improvements in rates of stillbirths and neonatal deaths are good, they are not shared equally among all women and babies. The Government is committed to reducing disparities in health outcomes and experience of care, and has responded to the points made by the Panel in relation to maternal disparities at Chapter 6.
17. The Committee's report states that funding for this commitment was not clearly set against demonstratable targets. As set out in a previous submission to the Panel, funding is not allocated on a commitment-by-commitment basis. This means that whilst some funding covers one or more of the commitments, other funding allocations are as part of a wider package of Maternity Transformation Programme (MTP) funding.
18. The Government acknowledges the issue identified regarding how the commitments have been set out and resourced. Funding provided to Local Maternity Systems (LMS) is given with a set of objectives but is not ringfenced to deliver certain initiatives. Funding is allocated in this way to allow LMS's to meet the needs of their local areas.
19. We also acknowledge the recurrent issues in establishing a robust and timely method of data collection and the need to develop appropriate data collection strategies to monitor progress where relevant data are not currently available.
20. The way maternity care is provided has been going through a whole- system transformation over the last five years and therefore is difficult to attribute change to individual initiatives. Interventions are evidence-based and/or in response to recommendations from case reviews and service inquiries such as Morecambe Bay.
21. The Government is committed to improving real-time data collection in relation to all four commitments. There is a continued focus on improving data quality with new initiatives to improve the digital maturity of Trusts. The development of interoperable electronic personal care records will enable real time data transfer from the maternity service to women. However, real time data transfer to the Maternity Services Data Set (MSDS) for analytical purposes is a very significant technical challenge which will take several more years to achieve.

Response

Stillbirths

22. Good progress has been made towards meeting the stillbirth element of the Ambition. The ONS reports that since 2010, the stillbirth rate has fallen from 5.1 stillbirths per 1,000 births to 3.8 stillbirths per 1,000 births in 2019, which equates to a twenty-five percent reduction in the stillbirth rate.
23. This places the Government firmly ahead of its target to meet the 2020 ambition for a twenty percent decrease and means that there are now at least 750 fewer stillbirths each year.
24. The Panel's report noted that whilst this achievement is commendable, it is too soon to determine whether the data for 2020 will sustain this progress and that stillbirth rates for 2020 during the COVID-19 pandemic are not yet available.
25. Whilst there is still much to learn about the impact of COVID-19 on outcomes, current findings from the UK Obstetric Surveillance System (UKOSS) and other studies show that the same women who have a greater risk of having a stillbirth are also at greater risk of becoming seriously ill after COVID-19 infection. This provides an important reminder of the need to keep women, babies and their families safe; and in particular the importance of vaccination for pregnant women and the use of testing to ensure that onwards transmission of COVID-19 is prevented.
26. There is still work ongoing to monitor the impact of COVID-19 on babies and stillbirths. UKOSS is conducting a surveillance study to determine the incidence of hospitalisation with pandemic COVID-

19 infection in pregnancy and assess the outcomes of pandemic COVID-19 in pregnancy for mother and infant. The Healthcare Safety Investigation Branch (HSIB) is also undertaking a national investigation into stillbirths that occurred during the COVID-19 pandemic from April to June 2020.

27. The Government will continue work to drive down the number of stillbirths and improve outcomes for mothers and babies.

28. The Government does not agree with the Panel's assessment that progress in reducing the number of stillbirths may be attributable to the continuation of an existing trend towards lower stillbirth rates. There has been an increased focus on maternity safety in recent years, which has driven implementation of Continuity of Carer models of care across England, which is evidenced[5] to positively impact on women's experience of care and to promote safer outcomes including a reduction in stillbirth, neonatal and maternal morbidity and mortality.

29. Additionally, in December 2020, MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reported that the largest reduction in mortality rates can be attributed to term stillbirths (37+0 to 41+6 weeks gestation), with a fall in mortality rates of almost one quarter (24.4%) over the five year period between 2014 and 2018. The Department believes this is likely to reflect initiatives in place across the UK focusing on the reduction of term stillbirths, as reference by MBRRACE-UK[6].

Neonatal Deaths

30. Good progress has also been made in reducing the number of neonatal deaths.

31. According to the ONS, there has been a twenty-nine percent reduction in the neonatal mortality rate for babies born over the 24-week gestational age of viability.

32. The Government notes the Panel's mention in its report that the charities Stillbirth and Neonatal Death charity (SANDs) and Bliss emphasise the importance of not excluding babies born before 24 weeks' gestation in the UKs ambition and work to reduce deaths.

33. Whilst changes in the measure of progress in terms of neonatal deaths against the National Maternity Ambition were made to take into account the impact of changes in clinical practice since 2010, the Government would like to emphasise that it remains committed to improving outcomes for all babies and mothers.

34. The ONS publishes the overarching neonatal death rate, which includes babies born showing signs of life for all gestational ages who subsequently died.

Brain injuries occurring during or soon after birth

35. As noted in the Panel's report, when the Ambition was set in 2015 there was no agreed definition of 'brain injuries occurring during or soon after birth'. The Department convened an expert group to develop a bespoke definition of brain injury. The Department is pleased to note that the Panel is satisfied that the definition captures potential late manifestations of brain injury to the greatest extent that is possible within the constraints placed on data collection.

36. The Department accepts that while there has been no overall reduction in the rate of brain injuries per 1,000 live births between 2012 and 2019, the data provided to the Panel represents a trend towards a reduction in brain injuries since the ambition was set in 2015, although this has not yet reached statistical significance.

37. Although progress against this element of the ambition has been slow, the Department believes it is now better placed to understand causes of such injuries, and to put in place specific, targeted interventions to make improvements in this area. Learning has been gathered from Maternity Safety programmes such as the Royal College of Obstetricians and Gynaecologists (RCOG) Each Baby

[5] https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-modelscare-women-during-pregnancy-birth-and-early

[6] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2018/MBRRACE-UK_Perinatal_Surveillance_Report_2018_-_final_v3.pdf

Counts programme, NHS Resolution's Early Notification Scheme and maternity investigations carried out by the HSIB.

38. To support a new programme to reduce brain injuries in babies the Department announced £2 million of funding in July 2021. The first phase of this programme is being led by the RCOG, the Royal College of Midwives (RCM) and The Healthcare Improvement Studies Institute at the University of Cambridge. It aims to develop clinical consensus on best practices for monitoring and responding to a baby's wellbeing during labour, and in managing complications with a baby's positioning, specifically when a baby's head is impacted in the mother's pelvis during caesarean section.

39. Funding for the second phase of this work, beginning later this year, will begin to implement and evaluate this new approach to inform how we can roll it out nationally. The views of women and birth partners will be taken into account in this work, to make sure we are getting it right for them.

Maternal Deaths

40. The Department accepts that no clear progress has been made towards reducing the 2010 rate of maternal deaths by 50% by 2025, and welcomes the Panel's acknowledgement that factors contributing to maternal deaths are predominantly indirect, such as existing disease, and therefore complex to address.

41. More work is needed to address the underlying causes of why mothers die in or shortly after childbirth.

42. MBRRACE-UK reports that in 2016-18, 217 women died in the United Kingdom during or up to six weeks after pregnancy. This represents a nine percent reduction in the maternal mortality rate against the 2009-2011 baseline. Fifty-eight percent of these were due to indirect causes such as cardiac disease and neurological conditions.

43. The Government believes that that a life-time approach is needed to support women to be in their best health before pregnancy. To care for pregnant women with acute and chronic medical conditions, NHS England is rolling out Maternal Medicine Networks, to make sure there is timely access to specialists at all stages of pregnancy.

44. Evidence shows that obesity during pregnancy puts women at an increased risk of experiencing miscarriage, difficult deliveries, pre-term births and caesarean sections. The report 'Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18'[7] by MBRRACE-UK states that more than half of women who die are overweight or obese.

45. The Government is committed to highlighting the importance of helping people to achieve and maintain a healthy weight to improve our nation's health, which is why it launched the obesity strategy[8] in July 2020. The strategy sets out a campaign to reduce obesity, including measures to get the nation fit and healthy, protect against COVID-19 and protect the NHS.

46. To reduce maternal and perinatal deaths, the causes of disparities in health outcomes and experiences of care also need to be addressed. The Department has responded to issues relating to maternal disparities raised by the Panel at Chapter 6.

Pre-Term Births

47. The pre-term birth rate ambition, announced by the government in the 2017 Maternity Safety Strategy, is to achieve a 25% reduction from an 8% baseline in 2015 to 6% in 2025.

48. The Department notes the Committee's assessment that this target was only introduced in 2017, which means the window for newly introduced measures to impact on data is narrow.

[7] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK_Maternal_Report_Dec_2020_v10_ONLINE_VERSION_1404.pdf

[8] Tackling obesity: government strategy - GOV.UK (www.gov.uk)

49. As noted in the Committee's report, a range of inter-connected initiatives have been implemented by maternity and neonatal professionals to support efforts to reduce pre-term births and optimise outcomes when preterm birth is inevitable. These include the Saving Babies Lives Care Bundle Version 2 (SBLCBv2); recommendations outlined in the Neonatal Critical Care Review, specialist preterm birth clinics, implementation of Continuity of Carer and the National Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). These initiatives have longevity for ongoing implementation through the NHS Long Term Plan.

3. Continuity of Carer

50. The panel rated the Departments progress against this commitment as follows:
    a. Overall – Requires Improvement
        i. Commitment Met - Inadequate
        ii. Funding – Requires Improvement
        iii. Impact – Requires Improvement
        iv. Appropriate – Good

Summary of Response

51. We welcome the Panel's clear message of support for national commitments on Continuity of Carer.
52. There has been a considerable amount of support from the NHS to help roll out Continuity of Carer models of care so far.
53. Significant staff shortages related to illness, self-isolation and redeployment during the COVID-19 pandemic has meant that many NHS maternity services had to suspend the roll-out of Continuity of Carer midwifery teams, and in some cases, suspend existing provision.
54. We acknowledge the Panel's concerns regarding the delayed, uneven, and unequal roll-out of this beneficial model of care. We agree that the strategy for implementation must be sensitive to the specific and longstanding challenges that Trusts face, and that more structured, individualised planning and support is needed to deliver the scale of transformation required, at a pace that women and families should expect.
55. We will therefore adopt a more individualised approach, where each LMS will meet with each Trust to assure their plans; assess their readiness to proceed; agree appropriate timescales for delivery; and ensure that transitional arrangements and support are in place to uphold the safety of care for all women across the service.

Response

56. We welcome the clear message of support for national commitments on Continuity of Carer. We agree that the strategy for implementation must be sensitive to the specific and longstanding challenges that Trusts face, and that more structured, individualised planning and support is needed to deliver the scale of transformation required, at a pace that women and families should expect.
57. There has been a considerable amount of support from the NHS to help roll out Continuity of Carer models of care:
    - Transformation funding of £90.05m was provided to LMS's between 18/19-20/21 for the fulfilment of programme objectives, including implementation of Continuity of Carer models.
    - Health Education England (HEE) have provided training to services across England to support delivery amounting to a £1.3m investment over three years. Harris et al (2020)[9] reflected that this was helpful for workforce engagement.

[9] Harris JM, Watts K, Page L, Sandall J (2020) Reflections on an educational intervention to encourage midwives to work in a continuity of care model – exploration and potential solutions, *Midwifery*, 88, p.102733.

- There is local, regional and national NHS England and NHS Improvement (NHSEI) support on implementation, including a dedicated National Lead for Continuity of Carer.
- NHSEI has published a Continuity of Carer workforce modelling tool to help maternity services plan their midwifery workforce to deliver Continuity of Carer.
- Patient Safety Learning guidance on provision of Continuity of Carer[10] is available online.

58. Although working to this model does not generally require additional midwives, an additional £95 million has been made available for maternity services in 21/22, which will establish additional midwifery posts.

59. Evidence from research and the experiences of women in England in the CQC Maternity Service survey has shown that Continuity of Carer is essential to improving the safety, equity and experience of Maternity care. This is why LMS's are already working towards a revised commitment for Continuity of Carer to be the default model of care, available to all women in England.

60. Within this, Trusts are already asked to take an individualised approach in planning, with a focus in 21/22 on each Trust putting in place the building blocks to support transformation. This includes setting out the scale of change required, and how this will be achieved alongside the fulfilment of required staffing levels, staff engagement and education and training of midwives. While many Trusts will be able to achieve this by March 2023, we recognise that a universal deadline for full implementation may not be achieved by every Trust.

61. We will therefore adopt a more individualised approach, where each LMS will meet with each Trust to assure their plans; assess their readiness to proceed; agree appropriate timescales for delivery; and ensure that transitional arrangements and support are in place to uphold the safety of care for all women across the service. While this individual approach to assurance of delivery plans and trajectories should be system led, it will require the input, oversight and support of regional and national Continuity of Carer Leads and therefore has resource implications for regional national maternity teams.

62. Consistent roll-out across England will need to ensure that women and families in certain areas are not disadvantaged through unwarranted delays in implementation. Next steps will be set out in revised national implementation guidance for Continuity of Carer, in the coming weeks.

63. We also recognise the need to monitor rollout, so that progress can be measured and lessons learned. While the MSDS has capability in place to measure Continuity of Carer nationally, this complex dataset requires high levels of digital maturity in trusts, and consistent, quality data capture over a number of months. Additional guidance and support will be given to Trusts so that all have capability by March 2022 to record and measure the provision of Continuity of Carer in routine care records. Improving data quality is also a focus of additional funding for digital maternity records, as set out in Paragraph 81.

64. A national evaluation strategy is in development, which includes rapid learning from the improvements and challenges identified in implementation so far.

[10] Midwifery Continuity of Carer: What does good look like? - Midwifery Continuity of Carer - Patient Safety Learning - the hub (pslhub.org)

4. Personalised Care

65. The panel rated the Departments progress against this commitment as follows:
    a. Overall – Inadequate
        i. Commitment Met - Inadequate
        ii. Funding – Inadequate
        iii. Impact – Inadequate
        iv. Appropriate – Requires Improvement

Summary of Response

66. We welcome the Panel's acknowledgement of the importance of personalised care for women and the need to fully embed the principle of informed consent into service delivery.
67. Personalised care planning in maternity services should be understood in the context of the Long Term Plan commitment to roll out the Universal Model of Personalised Care across the NHS.
68. NHSEI accepts that more work is required to communicate the concept and core principals of personalised care and support planning to clinicians and then to support the culture change required.
69. A communications plan is in progress which has to date included developing resources and baseline training for staff, plus a national webinar. An on-going programme of engagement and education is planned to ensure clinicians are empowered to deliver personalised care in a meaningful and sustained way.
70. An expanded training and support offer is planned to be in place by March 2022 incorporating existing and new resources and training.

Response

71. Personalised care and support planning is defined as '……a series of facilitated conversations in which the person actively participates to explore the management of their health and well-being within the context of their whole life and family situation, so that all considerations that may impact on safe care are accounted for'.
72. This definition is outlined in the national Personalised Care and Support Planning guidance[11] for maternity services and is grounded in the assessment, communication and management of risk, working within the five technical criteria for Personalised Care and Support Plans (PCSPs) as defined in the Long Term Plan strategic guidance.
73. The agreed PCSP is a live document that should reflect the decisions the woman makes about the care and support she wants to receive as she moves through her maternity journey. Those decisions should be informed by the discussions she has with her healthcare professional about the benefits and harms of the evidence-based options available at each step on that journey.
74. It should be recognised that although working towards having PCSPs in place by 2022 is a key first step, the provision of really high quality personalised care and support planning, including the

[11] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

requirement for non-judgemental and unbiased advice, requires a culture change away from historic paternalism and this will take time to become universal.

75. NHSEI accepts that more work is required to communicate the concept and core principals of personalised care and support planning to clinicians and then to support the culture change required.

76. A communications plan is in progress which has to date included developing resources and baseline training for staff, plus a national webinar. An on-going programme of engagement and education is planned to ensure clinicians are empowered to deliver personalised care in a meaningful and sustained way.

77. An expanded training and support offer is planned to be in place by March 2022 incorporating existing and new resources and training. This will be targeted at giving clinicians the skills and confidence to facilitate women's choice even where this may conflict with their views, and at embedding PCSPs into practice.

78. NHSEI is committed to supporting clinicians to deliver personalised care. To help clinicians develop their communication skills, NHSEI recently commissioned the Personalised Care Institute (PCI), to develop new e-learning and curate existing e-learning. The PCI also quality assures face-to-face training in communication skills. We commissioned the PCI to develop maternity specific training in personalised care and support planning, which was launched in April 2021.

79. Training in personalised care and support planning will form part of the multi-disciplinary Core Competency Training currently in development. This will ensure that the principles of developing leadership, culture and collaboration are delivered in an integrated way that can make best use of clinical time. There is a requirement that all staff undertake this training.

80. The MatNeoSIP, led by the National Patient Safety Team, provides support to Trusts on workforce culture whilst a network of Safety Champions in each Trust is well placed to ensure that services are compliant with General Medical Council guidelines on informed consent and that safety and personalisation align.

81. Resources for training to deliver PCSPs falls into three main categories:
    a. Sufficient workforce to enable time to listen to women and time for staff to be released for training – this will be supported by new funding received this Spring for an additional 1200 midwives nationally.
    b. Funding for MDT training, particularly to address core competencies - funding announced at the NHSEI Board in March 2021 will be put towards maternity multi-disciplinary team training and staff backfill as part of NHSEI's response to the first Ockenden Report.
    c. Funding for digital solutions – provision of digital PCSPs are one of the three key outcomes for the £52 million joint support package between NHSX and NHSEI announced earlier this year.

82. Personalised care and support planning in maternity services should be understood in the context of the Long Term Plan commitment to roll out the Universal Model of Personalised Care across the NHS. Every Integrated Care System has set out its plans to work towards the target of 2.5 Million people benefiting from Personalised Care by 2024.

83. Shared decision making has been shown to improve allocative efficiency – that is, aggregation of individual patients' informed choices enables an understanding of population demand for services which in turn leads to more informed demand planning and service configuration. Once personalised care and support planning is reliably in place to a high standard in maternity, informed demand will be better understood and will in turn drive any requirement for service planning and development.

84. It should be noted that whilst the NHSEI Commitment on Personalised Care is for all women to have a PCSP by 2022, an understanding of the services available to women is a much wider piece of work that currently lies outside the scope of PCSPs .

85. PCSPs are live documents which are continuously updated and refreshed throughout the pregnancy journey, they also encompass a wide range of evidence based choices and interventions which will

be offered over this time - this means that they are very difficult to measure, including whether, for example, a woman's choices, as set out in the PCSP, have been acted upon.

86. Currently the Maternity minimum data set can be used to record whether a woman has a PCSP using a yes/no box, and whether this relates to the antenatal, postnatal or intrapartum period. Submission of data for this metric is currently best for the antenatal period with an aim to improve data collection for other parts of the pathway this year. This collection is a limited first step as it is purely a quantitative measure and needs to be triangulated with quality measures, however we do expect to be able to provide data on uptake of PCSPs, split by ethnicity and deprivation, by Summer 2022.

87. However, given the range and dynamism of PCSPs, a qualitative approach is the only way to get a good sense of how well they are being implemented. Local audit of care plans as set out in the audit tool accompanying national guidance will provide assurance of whether or not personalised care planning is taking place as intended – that is, whether plans meet the five national criteria for what constitutes a PCSP. Given that this is a relatively time-consuming process, it is only ever likely to be practical to be carried out on the basis of a sample. Nevertheless, we will put in place a national programme to oversee this, so as to ensure that practice is consistent and we have a national understanding of how PCSPs are being implemented.

88. Other key measures of whether women have received high quality personal care and support planning (and the difference this has made) can be achieved by asking women for their experience. This assurance is obtained in two ways:

Nationally:

- The annual CQC survey of maternity services provides a composite measure on Choices in Maternity. This is an average score of the six maternity questions relating to choice in the survey. Results of this survey are published in the National Maternity dashboard. There are also a wider range of questions relating to experience of care which demonstrate personalisation

Locally:

- The published guidance on PCSPs in maternity recommends that LMS's carry out a survey of women's experience of services. This will provide local data which can be used for quality improvement. The MTP will be piloting a validated tool ('CollaboRATE') with a small number of Trusts later this year.
- Regions are asked to support and assure LMS are delivering against programme objective. They will be able to use the above information as evidence of LMS progress.
- A key part of facilitating the delivery of PCSPs is maternity digital transformation. This will facilitate sharing of information between the women and her clinicians and support the live and dynamic nature of PCSPs. NHSEI are committed to embedding ongoing evaluation and feedback into the digital journey, currently being developed in collaboration with NHSX as outlined in paragraph 81.

5. Safe Staffing

Commitment - Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.

89. The panel rated the Departments progress against this commitment as follows:

    a. Overall – Requires Improvement

        i. Commitment Met - Inadequate

        ii. Funding – Requires Improvement

        iii. Impact – Inadequate

        iv. Appropriate – Requires Improvement

Summary of Response

90. The Government recognises that professional staff is the NHS's most valuable asset, and the importance of ensuring that maternity units have the appropriate number and mix of staff to deliver high quality care for all women.

91. In March 2015, NHS England commissioned a national review of maternity services to assess the evidence from the UK and overseas on how care could be improved for women, babies and their families.

92. The National Maternity Review, led by Baroness Julia Cumberlege, published its report, 'Better Births'[12], on 23 February 2016, setting out recommendations for the future shape of modern, high quality and sustainable maternity services across the NHS in England.

93. The review called for care to become safer and more personalised. Importantly, the review recognised, right at the top of its vision statement, the importance of the workforce, and the importance of supporting and nurturing the workforce.

94. The Government acknowledges the report's finding that the ability to meet commitments relating to Maternity Safety, Continuity of Carer, and PCSPs heavily rely on having the appropriate number and mix of clinical professionals.

95. Additionally, the Committee's inquiry into the safety of maternity services also recommended that the budget for maternity services should be increased by £200–350m per annum with immediate effect, and that this funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as Trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.

[12] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

96. NHSEI recently invested £95m in maternity services to support the recruitment of 1,200 midwives, 100 consultant obstetricians, and the implementation of the Immediate and Essential Actions arising from the Ockenden Report.
97. This funding is being distributed to systems in 2021/22 based on regional assurance of improvement plans to ensure it has the best possible impact on safety, personalisation and equity, and will be put into Clinical Commissioning Groups (CCG) baselines in the longer term.
98. The Department remains committed to improving maternity safety and will take the recommendations made by the Committee and its Panel in relation to funding for staffing into consideration. As part of this, we will need to consider an assessment of midwifery and obstetric workforce levels. This assessment would also need to take into consideration time for healthcare professionals to partake in annual multi-disciplinary training and provide personalised care.

Response

The Midwifery Workforce

99. In its submission to the Panel, the Department set out that HEE undertook work in early 2021 to evaluate data produced by Trusts via a national midwifery workforce survey completed by NHSEI.
100. HEE' s analysis of the data identified there are currently **23,664** Full-Time Equivalent (FTE) midwives employed and in post, **24,508** FTE funded establishment midwife posts for 2020/21, and 25,596 FTE recommended establishment midwife posts for 2020/21, based on Birthrate Plus or the most recent board review of safe midwifery staffing. This gives a gap of **844 FTE** midwives between employed FTE staff in post and funded establishment, and a gap of **1,088** FTE midwives between funded establishment and Birthrate Plus recommended establishment.
101. As set out above, NHSEI has committed significant funding to meet the midwifery workforce gaps by funding an increase in establishment across England in 2021/22.
102. As of March 2021, there were over 6,300 FTE doctors in the specialty obstetrics and gynaecology employed in NHS trusts and CCGs. This is an increase of over 21% since 2010 and over 4% since last year.
103. As the Panel notes, Birthrate plus provides a framework to calculate safe midwifery staffing levels but no such tool exists for medical staffing. Medical staffing is complex due to a multitude of factors at unit, regional and national levels.
104. The Department has recently commissioned the RCOG, to develop a new workforce planning tool to improve how maternity units calculate their medical staffing requirements.
105. The tool will calculate the number of obstetricians at all grades required locally and nationally to provide a safe, personalised maternity service within the context of the wider workforce.
106. Additionally, The RCOG and HEE have created a joint Medical Workforce Group. The aim of this group is to explore and implement the deliverables for the development of the Obstetrics and Gynaecology (O&G) workforce outlined in HEE's Maternity Transformation Workforce Strategy. The purpose of the Maternity Workforce Transformation Strategy is to support NHS maternity services to deliver more personalised and safer care and improve outcomes for women by ensuring that there is the capacity in the workforce nationally.
107. The work is being progressed through five Task and Finish Groups, which are led by the RCOG. The groups focus on:
    a. Multi-Disciplinary Working – covering skill mix
    b. Workforce Profile and Modelling
    c. Rural and Urban workforce including best practice
    d. Flexible Working

e. Learning in O&G

108. The Department is working with partners to ensure that the number of training posts in O&G and also in anaesthetics, along with all other medical specialties, is in line with national and regional workforce requirements. We will continue to monitor the effectiveness of current arrangements, including considering the need for an expansion of training places.

Expansion of Midwifery Training Places

109. Since the Secretary of State announcement on 27 March 2018[13], and the publication of the Maternity Workforce Transformation Strategy[14], HEE has been working with stakeholders to support the expansion of midwifery training places in England.

110. As per the DHSC Mandate and Maternity Workforce Strategy, HEE is working to expand training placement numbers by 25% over four years.

111. This is to be achieved through an additional 650 places in 2019/20 and up to 1,000 places a year for a period of three years thereafter. The baseline year for this expansion to be measured against is 2018/19

112. There has been growth in the number of acceptances on to midwifery courses in England. For instance, in 2020, there were 3,630 acceptances to midwifery courses in England, an increase of 17% on 2019.

113. As part of this work, since September 2020 we made available a new, non-repayable, training grant of at least £5,000 per academic year for eligible applicants. Up to a further £3,000 funding is available, for example to help with childcare costs or specialisms struggling to recruit.

114. HEE has also pledged £15m to fund additional clinical placements across nursing, midwifery, allied health professionals (AHPs) and healthcare science, in 2021/22. This funding will increase the number of placements offered to nursing, midwifery, AHP, and healthcare students from September 2021, and will enable HEE to deliver the future health and care workforce in sufficient numbers and with the skills the NHS needs.

115. The funding will be used for extra supervision, and coaching models to support growth and will be allocated regionally to ensure it meets local demand. Some of the money will also be used to evaluate the quality, impact and value of this investment and consider capacity and funding options for the future. This funding is being provided in addition to the £180m spent each year by HEE on placements for around 120,000 nursing, midwifery and AHP students, as part of the clinical tariff.

116. The expansion project is working towards several objectives over the next year including building an infrastructure across England for placement activity and supporting the growth of placements to meet student intakes both now and in the future.

117. Further information on the work underpinning this target, including coaching models and education routes, can be found on HEE's website: https://www.hee.nhs.uk/our-work/maternity/midwifery-training-places-expansion

Retention and staff ratios

118. The retention of NHS staff, including midwives, is a key priority for the Government and essential for ensuring the NHS has safe levels of staffing. The Government is taking steps to ensure the NHS is an attractive place to work and where staff themselves feel cared for.

119. Flexible working is being made a core focus. From January 2021, all permanent roles now offer flexible working patterns and the percentage of posts advertised as flexible will be a key indicator of NHS performance. Employers also have the flexibility to operate a 'retire and return'

[13] https://www.gov.uk/government/news/women-to-have-dedicated-midwives-throughout-pregnancy-and-birth

[14] https://www.hee.nhs.uk/our-work/maternity/maternity-workforce-transformation-strategy

employment policy that allows retirement-age staff to claim their pension and reduce their hours whilst maintaining the same income.

120. Taking leave is important to allow staff the opportunity to rest and recuperate. The NHS already offers annual leave beyond the statutory minimum and it has allowed staff to carry over any leave they were unable to use during the pandemic.

121. Staff mental health is also a core concern given the immense pressure placed on staff over the last 18 months. 40 mental health and wellbeing hubs are being established in every part of the country, and with 36 now live they are providing proactive outreach and assessment services to all NHS staff. £37 million has been invested to ensure the hubs remain in place for the remainder of 2021/22.

122. The NHS People Plan recognises the need to ensure staff feel valued and supported at work. NHSEI has provided organisations with the Civility and Respect toolkit that is helping them tackle bullying and harassment and to create a compassionate and respectful workplace culture.

123. Freedom to Speak Up Guardians are in place in every NHS organisation and work with leadership teams to ensure workers' concerns are heard and dealt with appropriately at the right level. They provide support and a listening ear if staff wish to raise a concern and they can also act as an escalation point for people who want to speak up.

124. For the obstetrics and gynaecology workforce specifically, attrition is a key focus across each of the joint RCOG/HEE workforce subgroups. A group of expert clinicians are specifically exploring the following areas with the aim of reducing attrition:

- identifying the issues related to attrition in the workforce and desired outcomes for improving attrition;
- identifying what changes are required - looking at systemic changes and shifting from focus of individual failure; and
- identifying any workforce development requirements.

125. HEE have also introduced Less than full time training (LTFT), which allows medical trainees to choose to train LTFT to meet their individual professional or lifestyle needs. LTFT Category three was launched in O&G in 2019 with the aim to reduce attrition and improve the working lives of O&G trainees by offering an opportunity for improved work-life balance.

126. HEE has also made steps towards improving retention in O&G via flexibility in training through its Out of Programme Pauses (OOPP) initiative, and offering a number of posts at ST3 level so that trainees with enough experience and who may have stepped off the O&G run-through training programme after ST2 can resume their programme. HEE are monitoring those training LTFT to ensure that this does not reduce the overall numbers of doctors in the workforce.

127. In September 2019, the Government announced a £210 million funding boost for frontline NHS staff which included a £1,000 (spread over three financial years to 2023/24) personal development budget for every nurse, midwife and allied health professional working in the NHS to support their continuing professional development.

6. Maternal Disparities

Summary of Response

128. The Government and NHSEI welcome the Panel's focus on health disparities. The Government acknowledges that there are disparities in maternal and neonatal outcomes and further work is needed to understand why this is the case and address the causes.

129. Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer and Misha Moore, the National Specialty Advisor for Obstetrics - public health, have been leading work to understand why mortality rates are higher, consider evidence about what will reduce mortality rates and take action to improve equity in outcomes for mothers and their babies.

130. Interventions to tackle health disparity feature in the NHS Long Term Plan, Phase 3 planning guidance and the 2021/22 planning guidance (implementation guidance)[15] which commits to the publication of equity and equality guidance.

131. The Government acknowledges the Panel's recommendation that the Government as a whole introduce a target to end the disparity in maternal and neonatal outcomes with a clear timeframe for achieving that target.

132. The committee rightly states, the underlying causes of health disparities relate to a range of issues beyond the remit of the Department. The root causes of disparities in health are a complex interaction between personal, social, economic and environmental factors.

133. The Government's full response to this recommendation is set out in 'The Government Response to the Health and Social Care Committee report on the Safety of Maternity Services in England'.

134. It would not be appropriate to set the NHS a hard target for a specific level of reduction in a particular health disparity over time. Instead, NHSEI have taken the approach of first setting metrics which have sufficient sensitivity (statistical power) to track changes in clinical outcomes for the groups most at risk, and second – through the equity and equality guidance - to identify priorities, design evidence-based interventions to address those priorities and promote an approach of continuous quality improvement.

Response

135. For the past three years NHSEI have been working to address the findings of the MBRRACE-UK reports about maternal and perinatal mortality, which show worse outcomes for mothers and babies from black, Asian and Mixed ethnic groups and those living in the most deprived areas.

136. Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer and Misha Moore, the National Specialty Advisor for Obstetrics - public health are leading this work. The work aims to understand why mortality rates are higher, consider evidence about what will reduce mortality rates and take action to improve equity in outcomes for mothers and their babies.

137. The MTP is a priority programme in terms of addressing health disparities. Interventions to tackle health disparities feature in the NHS Long Term Plan, Phase 3 planning guidance and the 2021/22 planning guidance (implementation guidance) which commits to the publication of equity and equality guidance and asks LMS's to:

    a. submit an equity analysis (covering health outcomes, community assets and staff experience) and a coproduction plan by 30 November 2021; and

[15] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

b. coproduce Equity Action Plans by 28 February 2022.

138. The equity & equality guidance for LMS's sets out the NHS' response to the findings of the MBBRACE-UK reports about maternal and perinatal mortality, which show disparities in outcomes for mothers and their babies from black, Asian and Mixed ethnic groups and mothers living in the most deprived areas and their babies. The guidance sets out what action the NHS is taking and plans to address health disparities:

    a. describes the support available to LMS's to address health disparities, which includes £6.8m of funding in 2021/22 to co-produce equity and equality action plans and implement targeted and enhanced continuity of carer

    b. aligns to the five priority areas to tackle health disparities set out in the 2021/22 planning guidance (implementation guidance).

    c. sets out NHS plans to address the social determinants of health and, reflecting the NHS Long Term Plan, call on the public, private and third sector to take an even greater role to address these

    d. calls for better implementation of the Workforce Race Equality Scheme in maternity and neonatal services, noting the strong evidence highlighted in the NHS People Plan that "…where an NHS workforce is representative of the community that it serves, patient care and…patient experience is more personalised and improves"

    e. The equity & equality guidance for LMS's has been developed by examining the evidence and through a consultation process which has included Maternity Voices Partnerships, service user voice representatives, NHS staff, LMS's, Royal Colleges, academics, Arm's Length Bodies, Government, the VCSE and others. NHSEI is grateful to all those who have contributed. The contributions received have strengthened the guidance. Parents consulted reflect a range of ethnic backgrounds and geographies.

139. As the committee rightly states, the underlying causes of health disparities relate to a range of issues beyond the remit of the Department.

140. Recognising that the social determinants of health have a significant influence on health outcomes, DHSC facilitates cross-government working. For example, the Health and Wellbeing Fund is a joint initiative between DHSC, Public Health England and NHSEI and is investing £7.65 million in the VCSE sector over three years from 2020/21 to reduce health disparities among new parents and babies.

Metrics

141. Given that the social determinants of health are beyond the control of health services - requiring sustained and significant action across government, businesses and civil society - it would not be appropriate to set the NHS a hard target for a specific level of reduction in a particular health disparity over time. Instead, NHSEI have taken the approach of first setting metrics which have sufficient sensitivity (statistical power) to track changes in clinical outcomes for the groups most at risk, and second – through the equity and equality guidance - to identify priorities, design evidence-based interventions to address those priorities and promote an approach of continuous quality improvement.

142. For this reason, the NHS will measure progress against its equity aims for mothers and babies through metrics described in the Equity and Equality Guidance for LMS's.

Perinatal mortality metrics

Indicator: The stillbirth and neonatal mortality rate per 1,000 births for black and Asian babies divided by the rate for White babies in the UK, expressed as a ratio. Source: MBRRACE-UK

Accountability arrangements	Baseline (2017)
Long Term Plan headline metric	1.7

Indicator: The modelled difference in the stillbirth and neonatal mortality rate per 1,000 births between the most deprived and the least deprived communities in England, measured using the slope index of inequality. Source: ONS

Accountability arrangements	Baseline (2017)
Long Term Plan headline metric	4.39

Plans for an English Maternal Morbidity Outcome Indicator

143. Whilst even amongst women from black ethnic groups maternal deaths are rare, for every woman who dies 100 women have a severe pregnancy complication or 'near miss' - when she survives but often with long term health problems. Disparities in the numbers of women experiencing a near miss exist between different ethnic groups. Near misses are more common than maternal deaths, so we can investigate disparities at LMS or regional level to assess local variation and identify areas with best practice. The Policy Research Unit in Maternal and Neonatal Health and Care has been asked by the DHSC to investigate disparities in 'near misses', through the use of the English Maternal Morbidity Outcome Indicator (EMMOI)[16], which assesses the rates of various pregnancy complications and can, in contrast to investigation of maternal deaths, be compared across regions or LMS.

[16] Nair M, Kurinczuk JJ, Knight M (2016) Establishing a National Maternal Morbidity Outcome Indicator in England: A Population-Based Study Using Routine Hospital Data. PLoS ONE 11(4): e0153370. DOI: https://doi.org/10.1371/journal.pone.0153370

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